MASSACHUSETTS PAYMENT REFORM:

An Overview of Critical Foundational Issues

OCTOBER 2009

MHA Massachusetts Hospital Association

The leading voice for hospitals.

Executive Summary

In the Chapter 305 of the Acts of 2008, the legislature established a Special Commission on the Health Care Payment System and MHA's President, Lynn Nicholas, was a member of that Commission. This past summer, the Commission issued its recommendations and now the legislature and the Administration will step forward to consider those recommendations. The Commission recommendations set out a conceptual model for a new healthcare system based on a global payment model – a very ambitious set of recommendations that would fundamentally change the way that healthcare is organized and paid for in Massachusetts. But many key questions were left unanswered.

Given its size, complexity, and importance to the state's economy and health, it is not an exaggeration to describe transforming healthcare as a monumental challenge. But it is a challenge that must be embraced and one that can lead to a better healthcare system for those who receive, provide and pay for care. In fact, there is much significant change that is already underway in healthcare, aimed at improving quality, accountability, transparency, efficiency, and affordability. Understanding what is already changing, which changes are succeeding and which are not, and how to build on those successes is obviously essential if we are to achieve real and lasting transformational change. It is a challenge even more daunting than achieving near universal coverage. But it can be done by working carefully, creatively, and collaboratively – this is a way of achieving reform that has worked for Massachusetts before.

At its core, the Commission's recommendations envision a more efficient, coordinated and collaborative delivery system that is supported by a fair and affordable payment system. That is a vision that MHA and its member hospitals share. But how to achieve that vision is the challenge before us.

With that objective in mind, MHA seeks to shed light on some foundational issues that policymakers must address before plunging into a new payment system. Massachusetts hospitals believe that these foundational issues are too important to be addressed "after the fact", or as reform is being implemented. The hospital community shares a common goal and commitment to both raise and address these foundational issues. These issues must be raised and addressed upfront so that reform can proceed, so that reform can succeed, and so that reform can be sustained. From a hospital perspective, there are five such foundational issues which are examined in a series of briefing papers which MHA will release during October. Attached is an introductory briefing paper that provides an overview of all five foundational issues:

- **The transfer of financial risk to providers:** In a global payment system, providers would receive a predetermined fixed amount to provide care to a particular patient population, an amount that would be 'risk-adjusted' for the health status of the patient. This means that providers would take on some degree of financial 'risk' to an extent greater than today — risk that the payment amount would not be adequate to cover the costs incurred for care. In theory, this would incentivize providers to be more efficient in the provision of care that they are now and this would keep costs down.

  How is the nature and level of this "risk" to be determined and managed? The risk should be clearly within the providers' scope of control, clearly defined and not subject to interpretation. Comprehensive and accurate risk adjustment methods would be required — inadequate risk adjustment could doom the proposed global payment system to failure.

  Under global payments, insurers would be transferring much of their risk to hospitals and doctors. This raises the issue of whether insurers would be required to transfer a commensurate amount of their reserves to hospitals — such a requirement would be necessary and fair. If the transfer of risk is not carried out in a thoughtful and deliberative manner, it could

have unintended, unfortunate consequences for the state's healthcare delivery system.

- **Benefit Design, Enrollee Choice and the Role of Employers:** A global payment system would make those who provide care more accountable for coordinated care. It is necessary that this be coupled with thoughtful changes in the design of insurance benefits so that patients too are encouraged and incentivized to get their healthcare within smaller, interconnected communities of quality providers. To this end, it is vital to educate, engage and secure the commitment of employers, payers and consumers in this process upfront. Virtually unlimited access and choice would render the prospect of truly reducing costs a hollow promise.

- **Formation of Accountable Care Organizations:** The proposed payment system would organize providers, including hospitals and physicians, into new entities called "Accountable Care Organizations" (ACOs). The care of a 'critical mass' of patients would have to be paid for using the new payment system to justify the infrastructure and other investments needed to operationalize under the new system. Potential barriers to the attainment of this critical mass should be identified and overcome. ACOs must be capable of developing, supporting and sustaining necessary primary care services. We must develop the guidelines for the formation and operation of ACOs; and we must determine upfront the nature and cost of IT infrastructure and other resource requirements. Virtually all providers will face serious challenges in funding these investments — and how these will be overcome should be addressed upfront.

- **Societal Needs:** In a payment system that seeks to determine cost based primarily on the direct care provided to a patient, how are broader and essential societal needs to be addressed? Such needs cover: maintenance of essential hospital capacity on a 24/7 basis of all hospitals including those that primarily serve patients who are economically disadvantaged; medical education, uncompensated care, and behavioral health covered. And how can we avoid and smooth the economic dislocation that can accompany massive change and the consequential loss of jobs? Such questions have been raised, and need to be answered.

- **Oversight Entity:** In a system that envisions a single oversight entity to determine the balance between the market power and government regulation, how is such an entity held accountable while being independent, what is its authority, and how is it funded? Should there be such a single entity? Such foundational issues need to be understood, discussed and addressed before committing to creating such an entity.

Payment reform alone is not a panacea for escalating healthcare costs or for improving the delivery of care, but it is an important component of what should be a comprehensive approach to reform. As the Rand study on "Controlling Health Care Spending in Massachusetts" noted: "There are no silver bullets..., but there are multiple options that would reduce spending". The Rand study goes on to point out that "estimates of savings from all options are very uncertain because none has a proven history of reducing spending."

So with the compelling vision of a more efficient, coordinated, and collaborative health care system before us and a realistic appreciation of the challenge before us, let us move forward.

MHA welcomes the discussion surrounding of these issues. If you have questions or suggestions on any aspect of this briefing paper, please do not hesitate to contact us.

Payment Reform in Perspective

The Special Commission on the Health Care Payment System (created by Section 44 of Chapter 305 of the Acts of 2008) completed its work and issued specific recommendations for transforming the healthcare payment system in Massachusetts. Now the responsibility for reviewing those recommendations and deciding what course payment reform will take in Massachusetts is in the hands of government leaders informed by stakeholders who will be affected by reform.

Hospitals Support Reform

There is strong support from the vast majority of Massachusetts Hospital Association's (MHA's) members for reform of the healthcare payment system. There is general agreement that the current system falls short of meeting the reasonable expectations and needs of – most importantly – patients, but also of those who provide care and those who pay for it. The status quo is not an option moving forward. Hospitals agree that a more integrated and coordinated system of care would have positive results in terms of access to, and quality of, care. The general direction of payment reform away from fee-for-service towards a more integrated form of delivery and reimbursement – such as global or bundled payments – could be successful.

However, the challenge of deciding how to shape a new payment system is enormous not only because of the complexity involved and the immense size of the healthcare system, but because the consequences of doing it incorrectly can cause significant and unintended harm to the health care system across the state and the commonwealth's economic wellbeing. And, the benefits from successful reform are too great and too valuable to miss. A challenge this big, a change this important, is worth taking the time upfront to do it right.

In this paper we outline the importance of the role of the healthcare industry as an economic engine for the state; we discuss ways in which hospitals and other providers are currently working in collaboration with other stakeholders to take meaningful steps to reduce and control health care costs and improve the quality of care. We provide a brief description of some interim steps that could be taken to move us towards comprehensive reform and finally, we provide an overview of critical foundational issues that must be addressed before a fundamental and comprehensive reform of the payment system along the lines of the Commission's recommendations becomes law.

More Discussion Needed

MHA will be releasing separate briefing papers with in-depth analyses of these critical foundational issues in the weeks to come, with the intention of guiding and enhancing the public discourse as we pursue this transformational change in our health care system. At the end of this paper is an outline of the issues we will address in our briefing papers.

Our Commitment is

Hospitals are already deep into healthcare reform in Massachusetts; hospitals already are taking steps to reducing/controlling costs in a responsible way without hurting care quality/outcomes.

- Massachusetts is currently participating in many projects to address and improve hospital readmission issues. These efforts are largely coordinated state-wide by the **Massachusetts Care Transitions Forum**, a collaborative of more than 110 members representing some 50 organizations throughout the Commonwealth. The forum's mission is to improve the quality of care transitions when patients are moved from one care setting to another, whether it is to a different unit in the hospital, to a different care facility, or discharging to home. Improving these transitions should result in the elusive "triple-win" in healthcare: care that is of higher quality, lower cost, and patient-centered.
- Acute care hospitals are participating in the Potentially Preventable Readmission (PPR) Pilot Project. Their goal is to evaluate readmission measure methods and the utility of readmission rate reports for quality improvement and public reporting purposes.
- Massachusetts is one of three states participating in the State Action on Avoidable Re-hospitalizations (STARR) initiative. STAAR seeks to work across organizational boundaries to reduce avoidable re-hospitalizations by 30 percent state-wide and increase patient and caregiver satisfaction with the care received.
- Providers and commercial payers are exploring new payment methodologies such as Blue Cross Blue Shield of Massachusetts' Alternative Quality Contract and others
- A voluntary collaborative to promote administrative simplification in healthcare business transactions, involving MHA, the Massachusetts Medical Society and Massachusetts Association of Health Plans, three individual health plans and several prominent medical groups, has been meeting since last April. This collaborative's first project is simplifying eligibility verification; and it will also be starting work soon on reducing duplicate claims submissions. Future projects will include streamlining provider appeals processes and standardizing medical policies.
  This work should pay off since MHA estimates that the cost of billing and insurance related activities for the state exceeds $5 billion per year, and these costs have been rising faster than other healthcare costs in recent years.
- Hospitals are also signing up to collaborate with medical home demonstrations through the Massachusetts Patient-Centered Medical Home Initiative.
- LEAN and Six Sigma re-engineering efforts are underway in many hospitals across the state.

Already in Action

- There is increasing implementation of Nurse Staffing Councils to provide caregivers more say in patient care staffing.
- Numerous quality and patient safety efforts are underway:
  - » First-in-the-nation voluntary posting of nurse-specific quality measures on MHA's *Patients First* web site.
  - » Massachusetts is the second state, to implement voluntary non-charging for care related to Serious Reportable Events (SREs) that are within control of the hospital.
  - » There are more than 150 hospital quality & safety measures that are part of the hospital performance measurement landscape in Massachusetts under the sponsorship of public/private-sector organizations in Massachusetts or across the nation.
  - » The Massachusetts Hospital Association was selected to partake in "The National Implementation of the Comprehensive Unit-Based Safety Program to Reduce Central-Line Associated Blood Stream Infections in the ICU." The program seeks to change hospitals' infection-fighting culture through the adoption of a Comprehensive Unit-Based Safety Program (CUSP).

Reform is also underway as a result of legislative or regulatory mandates:

- Implementation of new hospital utilization management and financial reviews, as the state has discontinued Payment for Serious Reportable Events; new reporting requirements and non-payment rules are in development around Healthcare Acquired Infections; new Race & Ethnicity data reporting requirements for numerous state agencies and CMS;
- The new state web site sponsored by a legislatively enacted Health Care Quality and Cost Council displays cost and quality measures for all of the state's acute hospitals.
- Massachusetts has a new mandate for Patient and Family Advisory Councils at acute, long-term care, and rehabilitation hospitals; as well as a new mandate for hospitals' Rapid Response Methods, with additional requirements beyond the Joint Commission standards.
- Based on the recommendation of an expert panel on health-care-associated infection, and the authorization of the Public Health Council, acute care hospitals are now required to register with an infection measure reporting system, report infection data, and authorize the release of hospital-specific information and reports to state agencies.
- As a result of Massachusetts legislation, an expert panel on end of life care for patients with serious chronic illnesses has been convened. The panel is investigating and studying health care delivery for these patients and variations in delivery of such care among health care providers in the commonwealth. The panel has been charged with identifying best practices for end of life care, including those that minimize disparities in care delivery and variations in practice or spending, and shall present recommendations for changes.

Massachusetts hospitals provide renowned, exceptional healthcare and serve as a major economic engine

Massachusetts is privileged to be one of the leading regions in the world for biomedical research, medical and health professional training, and state of the art medical facilities. Massachusetts hospitals and our healthcare system are renowned across the world. Our hospitals provide care for a wide variety and intensity of conditions, and provide the essential services needed in a community e.g. care of AIDS patients, burn care, intensive care, neonatal and pediatric services, obstetrics and trauma care etc. They provide the 24/7 back-up and safety net for the entire community as well as for other care providers; they provide community health education programs and preventive services. They educate the next generation of physicians, nurses, and technicians. Through their research role, hospitals attract and keep the "best & brightest" and make significant contributions to the healthcare knowledge base, new therapies and technologies.

For many communities, the hospital's very existence serves as a community benefit, both as the essential medical provider and a major employer-providing jobs for all skill and economic levels.

- 187,000 – The number of people employed[1] at MA hospitals.
- The creation of hospital jobs supports the creation of jobs in other industries because hospital employees purchase goods and services in the community at large. In Massachusetts, each hospital job results in 2.1 jobs[2] in the economy as a whole. So the total number of jobs created both directly and indirectly by hospitals is 365,400.
- 504,000 – People employed in direct care + medical industry + research[3] – that's **15.8 % of total Massachusetts employment**
- Significant funds flow into Massachusetts for medical research, education, and services. The state ranks second (to California) in grants from the National Institutes of Health (NIH), receiving $2.23 billion in 2007[4]. The City of Boston, for 14 consecutive years, has led all U.S. cities whose institutions received NIH funding, garnering $1.6 billion in NIH grants in 2007.
- More than 14% of Massachusetts' "gross state product" is tied to healthcare providers.

Interim Steps are a Prescription for Effective, Comprehensive Change

MHA suggests four complementary strategies – a transitional glide path – which would move us in the general direction of payment reform in incremental stages. These would help the healthcare system and hospitals position themselves for new payment systems. We divide these into four categories:

A.) ANALYSES AND PAYMENT ACTIONS
B.) INVESTMENT IN AND DEVELOPMENT OF INFRASTRUCTURE
C.) SUPPORT FOR PRIMARY CARE
D.) STANDARDIZE MEASUREMENT

A.) ANALYSES AND PAYMENT ACTIONS:

- **Developing comprehensive databases on current utilization of services by patients:** It will be impossible for providers to operate as an Accountable Care Organization (see further ACO discussion below) in a global payment system if there is no data about patient utilization/costs that will allow ACOs to develop strategies for care coordination and cost control. The state could potentially work through an entity such as Massachusetts Health Quality Partners to provide such data. For example, if a hospital wants to help reduce readmissions, it's essential to know what is happening to the patients after they leave the hospital. For example, do they follow up with a primary care physician (PCP)? Do they get their prescriptions filled? Are they following through on exercise, diet and other lifestyle changes? Some payment changes could be important building blocks for future payment systems. Early adopters of these changes should be engaged and incentivized and their experiences disseminated to aid additional adoption or identify courses of correction:
  - » **Implementation of Pay-for-Performance as a baseline in all healthcare settings:** A number of public and private payers are considering and testing "incentive payments" to reward provider performance. We support the concept of aligning payment incentives with the provision of high-quality care, but recommend moving forward thoughtfully by, for example, employing standard, evidence-based measures.
  - » **Adopt different payment systems in different settings:** We support steps to encourage clinical integration and coordination between acute and post-acute care. Different payment systems could be tried in different settings, and in this way, sufficient experience would be built up with, and comparative data derived from, alternative payment methodologies. For example: medical home in some settings; bundled payments in others; global payments in some settings, and episode based payments in some settings. This should be coupled with careful planning about how to integrate these systems into a global payment system. For example, if there is an expectation that an ACO will want to use episode payments for "out of network" care, that should be the focus of testing episode payments. Some of these efforts may provide policymakers with alternative models of payment in situations where global payments may not be feasible.
  - » **Ensure government is a good partner by fulfilling Medicaid commitment of Chapter 58 as first steps to address the public-private cost shift:** While progress was made initially, MHA's current assessment is that the underpayment gap for hospitals will be larger in 2010 than before the reform law was enacted. The continued existence of, and growth in, the underpayment gap lowers the likelihood of successful payment reform. In addition, the government's backing off from its commitment to fill the underpayment gap undermines provider confidence in the ability of the government to be a reliable partner in payment reform.

B.) INFRASTRUCTURE:

Secure commitment from all payers to support infrastructure needed to build Accountable Care Organizations (ACOs), and, in particular, to support the development of health information technology (HIT) – for example, electronic health records (EHRs) to provide clinicians with important patient information and clinical decision support tools needed to provide safe,

high-quality care. We have to accelerate the adoption of HIT by addressing the financial, regulatory and technological barriers, including inter-operability and standardization.

C.) PRIMARY CARE:

- **Escalate efforts to increase PCP supply:** Make the investments necessary to ensure a strong and sustained primary care workforce; encourage practitioners to choose primary care as a profession. In addition, modernize provider training and education to include a focus on keeping people healthy, diagnosing and treating chronic disease, and working in teams to manage complex patients. In spite of recent legislative efforts to improve primary care capacity and extend the role of nurse practitioners and physician assistants, there are still primary care shortages in the state.
- Secure employer commitment to **insurance products that encourage selection of PCPs** by all insured. Payment changes only affect one side of the relationship; insurance products must enable and incentivize patients to choose and allow a provider to coordinate care.
- Employers and insurers must support efforts to encourage healthy behaviors through product design and additional workplace incentives.

D.) MEASUREMENT:

Metrics can be used for comparison of effectiveness across all payers and providers; but we must ensure that reporting measures for quality, patient safety and access – both existing measures and any new ones – are standardized and do not add to the already significant administrative costs within the system.

Glossary of Terms

Accountable Care Organization: A set of providers held responsible for the quality and cost of health care for a population of patients.

Readmissions: Patients discharged from an inpatient stay may find themselves back in the hospital within 30 days: some of these readmissions are planned, and others may be part of the natural course of treatment for specific conditions; but, increasingly, some hospital readmissions are being thought of as avoidable and as "indicators of poor care or missed opportunities to better coordinate care.

Primary Care Physician: A physician, such as a general practitioner or internist, chosen by an individual to serve as his or her health-care professional and capable of handling a variety of health-related problems, of keeping a medical history and medical records on the individual, and of referring the person to specialists as needed.

Pay for Performance: "P4P" is a term that describes health-care payment systems that offer financial rewards to providers who achieve, improve, or exceed their performance on specified quality, cost, and other benchmarks. Most approaches adjust aggregate payments to physicians and hospitals on the basis of performance on a number of different measures. Payments may be made at the individual, group, or institutional level. Performance may be measured using benchmarks or relative comparisons.

Medical Home: Medical Home models provide accessible, continuous, coordinated and comprehensive patient centered care, and are managed centrally by a primary care physician with the active involvement of non-physician practice staff. Providers deemed a medical home receive supplemental payments to support operations expected of a medical home. Physician practices may be encouraged or required to improve practice infrastructure and meet certain qualifications in order to achieve eligibility.

Global payments: Fixed-dollar payments for the care that patients may receive in a given time period, such as a month or year. Global payments place providers at financial risk for both the occurrence of medical conditions as well as the management of those conditions.

Episode-based payment: Reimburse providers on the basis of expected costs for clinically-defined episodes of care. Episodes of care are typically defined on the basis of selected conditions or major procedures, and include clinically related services provided by various providers over a period of time. Episode-based payments may also be adjusted for severity of illness and quality performance.

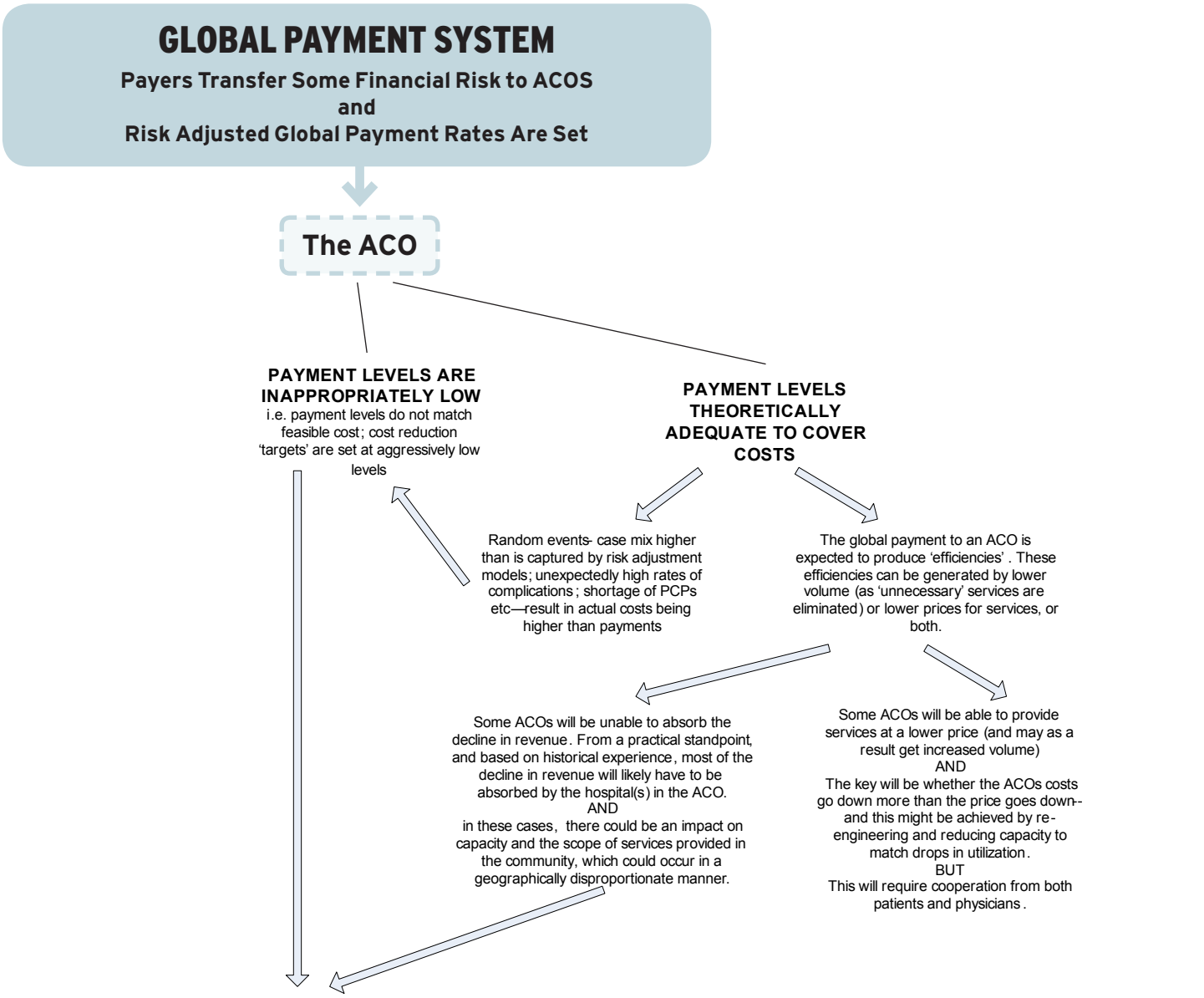
Risk: The probability that favorable outcomes/events will not occur or that unfavorable outcomes/events will occur.

Benefit Design: The determination of the terms of a health benefit package. The benefit package refers to the services and providers that are covered by a health insurance plan, and to the financial and other terms of such coverage (e.g., patient cost-sharing, limitations on amounts and numbers of visits or days).

ERISA: The Employee Retirement Income Security Act (ERISA) is a federal law regulating the administration of private employer-sponsored benefits including health benefits.

Adequate Payment is Key

Before we go into further detail on the foundational issues, we have to emphasize that *irrespective of what payment system is used*, if the payment levels are set too low as a result of over-aggressive cost reduction targets then providers will be unable to deliver quality care and the new model of payment will be doomed to failure. Further, in a global payment system, even if payments are set at levels that are theoretically adequate to cover costs, random events and circumstances beyond the control of providers can result in actual costs being higher than payment levels. The schematic below illustrates some of the ways in which the shift to a global payment system could have unintended consequences:



Delivery system changes could occur in an unstructured and unplanned way with potentially serious consequences for the commonwealth or specific geographic areas withing the commonwealth.

SO

It is imerative that we price and plan appropriately so that reductions in capacity match reductions in utilization and reduction in prices match actual reductions in cost.

The global payment system that the Special Commission named as a likely alternative to the current fee-for-service system is expected to produce efficiencies and translate to lower prices for payers. These efficiencies can be generated by lower volume (e.g. unnecessary services are eliminated) or lower prices for services, or both. The key issue therefore is whether an ACO is actually able to provide services at a lower price and reduce its costs as much or more than the price goes down. Another critical issue is that the price is set at a level that continues to support the cost of societal needs (as described below).

Some ACOs (and the hospitals in the ACO) will be able to re-engineer to achieve efficiencies and to cut costs by matching reductions in capacity to reductions in utilization. However, other ACOs might not be able to do so. From a practical standpoint and given historical experience, the resulting declines in revenue will likely be absorbed by the hospital(s) in the ACO; this could result in reductions in hospital capacity and the scope of services provided in a community.

Some degree of health care delivery system 're-engineering' i.e. modification of existing processes and systems, would presumably be a consequence of payment reform. Some such change would be acceptable and even desirable. Some people might feel that even the loss of some hospital capacity is acceptable. However, it is difficult to argue that such delivery system changes should be left entirely to market forces, without public health and population- based analyses and planning. If such decisions are not to be left completely to the market, what is the role of government in such decision-making? Is the intention to return to the government planning model that was employed in the past?

We must also acknowledge that cost reduction and cost control efforts may require some shifts in jobs, purchasing, etc. Given the size and importance of the healthcare sector in the state, these shifts can have significant effects on communities and the economy. For example, if volumes decline, there may be staff dislocations; state workforce programs should be prepared to deal with this. Slower growth in spending would also mean less job growth in the healthcare sector, where workforce programs have been projecting continued job growth for years, and have been encouraging people to enter health careers training programs with the expectation that there will be enough jobs.

Another issue to consider is that a radical change in the way that providers, including physicians, are paid in Massachusetts could make it more difficult to recruit and retain physicians in the state. This is especially worrisome given the critical shortages that already exist in several specialties in the state. If such change will not have a negative impact upon physician recruitment and retention, we should know that in advance.

Five Critical Foundational Issues Must Be Addressed Before Implementation

Critical questions must be answered, foundational issues must be resolved, and key steps must be taken before committing to a specific new system of delivering and paying for care. The legislature and policymakers should proceed with caution and in a thoughtful manner to enact responsible reform.

[Our initial concerns were outlined in detail in 'Preliminary MHA Perspective on Key Payment Reform Issues' dated July 7, 2009, which was provided to the chairs and members of the Special Commission.]

We have divided our concerns in five broad categories, though we recognize that there is considerable overlap between them:

A.) RISK-OPERATIONAL AND TECHNICAL ISSUES
B.) BENEFIT DESIGN, CONSUMER CHOICE AND THE ROLE OF EMPLOYERS
C.) ACCOUNTABLE CARE ORGANIZATION (ACO) FORMATION
D.) SOCIETAL NEEDS
E.) OVERSIGHT ENTITY: FORM & FUNCTION

A.) RISK: OPERATIONAL AND TECHNICAL ISSUES RELATED TO RISK

A key element of a global payment system is the transfer of some degree of risk to provider(s), which in theory would provide an incentive to "deliver the most effective care possible... and to integrate and coordinate care efficiently."[5] Our concern is that if the transfer of any degree of risk to providers is not carried out in a thoughtful and deliberative manner, it could have unintended, unfortunate consequences for the state's healthcare delivery system. Transferring risk could have more than just short-term financial consequences; the broader issue involves disruption of current business models and the implications for health policy and planning.

To avoid unintended consequences, we must identify and resolve **Operational** and **Technical** issues related to risk transfer to providers

A.) Operational Issues Related to Risk

We must ensure that the transfer of risk is based on the provider's scope of control and ensure that insurance products are made consistent with provider risk-bearing. Operational issues related to the transfer of risk to providers include the **Management of Risk**; and **Investment & Infrastructure Needs**.

Management of Risk:

The Special Commission recommends (emphasis added):

*"**Carriers will retain their current role as holders of insurance risk** for health insurance contracts written to groups and individuals. To ensure that ACOs are not subject to insurance risk, global payments will be risk adjusted (as described below). To further protect ACOs from insurance risk, carriers might develop stop loss or risk corridor arrangements with ACOs. However, **ACOs will be held responsible appropriately for performance risk** — including cost performance and meeting access and quality standards."*

- **Definitions of types of risk:** To understand the types of risk that ACOs will be taking on, we have to develop/obtain clear definitions of the types of risk associated with healthcare providers operating under global payment. The Commission did not provide such clear definitions.
  - » Risk has been defined[6] as the probability that favorable outcomes/events will not occur or that unfavorable outcomes/events will occur. For effective, efficient management of healthcare, three types of risk must be dealt with: **1) probability risk** or the risk of occurrence;

that is: all other things being equal, one person will become ill and another will not. Probability risk is also called insurance risk. **2) Technical risk** is the controllable risk of becoming ill, of not getting better or of having a bad outcome; this depends on the quality of the preventive, diagnostic and therapeutic services that an individual receives. Both providers and consumers have a role to play in technical risk. And then there is **3) Utility risk** which reflects each individual patient's preference for one outcome over another.

"There is no hard line distinguishing where insurance risk ends and performance risk begins. One patient may be harder to treat than another for the same condition or may have adverse reactions to treatment due to unmeasurable factors that are outside the control of a physician, making it difficult to say how much of the higher costs of treatment are an insurance risk vs. a performance risk. But it is clear that not all of the costs of health care should be considered pure performance risk — as traditional capitation systems would imply — and fewer health care costs are insurance risk than fee-for-service systems implicitly give insurers responsibility for."[7]

***Harold Miller**, From Concept to Reality: Implementing Fundamental Reforms in Health Care Payment Systems to Support Value-driven Health Care*

» Importantly, the patient/consumer has a role in the management of both technical and utility risk. Consumers can help reduce technical risk by adopting healthy lifestyles, and through compliance with recommended treatment regimes. Utility risk is driven by **consumer choice**, and consumers must have appropriate information and incentives to choose options that best meet their particular needs in a cost-effective manner. Patients/consumers, in cooperation with both payers and providers should manage their choice risk[8]. For consumers that are in employer-sponsored health plans, the **employer's role** is crucial in the selection of health plan offerings and benefit designs that encourage transparency, align incentives and reward the efficient and effective delivery of care.

» The Commission appears to have failed to recognize the critical role of consumers and employers in changing the inherent risk in a risk pool by placing no restrictions on enrollee choice or on plan design:

"An enrollee will not be restricted (unless as a condition of his insurance contract) to providers in his primary care physician's ACO, although his insurance contract might require him to pay more if he obtains care from providers in another ACO... Employers will also continue to play a critical role as health plan sponsors. While global payment as envisioned by the Special Commission will not require employers to modify their health plan designs, employers can maximize the benefit of payment reform by aligning the consumer incentives that are implicit in their benefit designs."

- We will need to determine readiness and appropriateness of risk-transfer to ACOs and evaluate whether there should there be different risk models for different types of ACOs. Should, risk transfer be tiered based on the size of the ACO? Should recommendations be made about minimum size and number of ACOs based on the ability to take on risk? It is increasingly difficult to adequately risk adjust payment to avoid insurance risk if a practice has only a small number of patients[9]. We must delineate patient types/services that would be **'carved out'** of global payments – e.g. rare disorders for which the hospital/medical/surgical care can be expected to be very expensive. If this occurs, how will the reasonableness of costs be addressed?
- **Financial reserves:** Adequate amount of risk-based capital or reasonable financial reserves and requirements would be needed to cover the risk providers would take on, and they would need to be given the opportunity and means to build up these reserves.
- While there is no absolute dividing line between insurance and performance risk, mechanisms such as risk-severity adjustment systems, stop-loss provisions, reinsurance etc. can help to keep insurance risk with payers and away from providers[10] We need to identify and recommend mechanisms – that work best to protect providers from risk and assess their availability to ACOs.
- There are factors outside the scope of providers' control that can affect their ability to successfully operate under a global payment system – for example, changes in input costs, workforce shortages. **Global budgets would need to be updated regularly and recognize market changes in these factors.** In addition, taking on additional financial risk could have unintended consequences on other aspects of a providers' operations, such as credit ratings and access to capital.

- We recognize that health care markets are local and somewhat unique; we should study providers in Massachusetts markets that are operating under global budgets – both to assess the specific characteristics that enable "success" under global payment arrangements and to evaluate whether capitation in this market helped to mitigate health care cost trends.

Investment and Infrastructure Needs:

Moving forward, we will need to identify and develop cost estimates of the resources needed to operate under a global payment system, including information technology, personnel and other infrastructure.

- Simulate a budget for a clinically integrated system and extrapolate from this the cost of statewide implementation. Determine how providers that do not have the resources to operate under the new system would be supported, either by being given more time or financial support or both.
- Recognize that in order to cover the cost of the infrastructure needed, there may be a need for higher provider payments initially (or amortized over a period of time) than would appear appropriate based on current costs of care alone.
- The state should "score" the Information Technology aspect of any payment reform legislation that is passed, recognizing that most providers do not have the IT capabilities to support a global payment system. These include the ability to accumulate health service utilization and health status data on their covered population in order to manage their care and to forecast where they stand relative to payments. IT capabilities would be needed for member service communications and management, and employer/purchaser communications and management.

B.) Technical Issues Related to Risk

Accurate and robust risk measurement and adjustment mechanisms will be needed in a global payment system. We need to identify the **models, tools and methods available** relating to patient and population health risk analysis and adjustment, particularly as it affects the capitated/global payment amounts paid to Accountable Care Organizations for individual patients or populations.

- Determine to what **degree these models are successful**; what their shortcomings are and what methods, if any, are used or needed to compensate for these shortcomings.
- Determine the **appropriate frequency and mechanism of payment adjustment/calculations** to ensure that payments match the actual case mix of patients being cared for and providers are not being forced to bear "insurance risk." Miller[11] notes that if an ACO is caring for a population of patients and the cost of that care goes up, the cost increase would need to be divided into the estimated share due to an increase in risk factors versus the estimated share due to an increase in the cost of treating individuals with the same level of disease severity. The ACO would be accountable for the later share of the cost increase but not the former.
- We also need to determine what mechanisms to put in place for **retrospective risk adjustment**; for example, health status and other demographic factors should be readjusted retrospectively at the end of every year.
- **Wider risk adjustment:** The Special Commission proposes to adjust not just for clinical status but for socio-economic status, geography, core access, quality incentives, and even "differences in consumer incentives associated with benefit design." We would need to assess whether there any models that successfully do all this.

B.) BENEFIT DESIGN; CONSUMER CHOICE & THE ROLE OF EMPLOYERS

Massachusetts healthcare coverage benefits are very rich by national standards. That is something of which to be proud. But policy makers must reconcile such benefit standards with their goals for payment reform. Current benefit design supports virtually unlimited choice of providers. In addition, the majority of Massachusetts employers offer plans with very low out-of-pocket costs, creating incentives for patients to use higher-cost providers and services even when not medically necessary. The Special Commission report presents a conundrum: there must be alignment between benefit design and consumer behavior in order for payment reform to succeed, yet the recommendations do not adequately address patient choice.

Because of the variety of economic and non-economic incentives inherent in the current health care system, benefit design is only one of the tools available to incent behavior.[12] Without drawing some parameters around benefit design and benefit levels, the risk to ACOs from non-compliant patients and bad debt could be very high.

A.) Minimum standards for benefit design should be defined to ensure that individuals get the care they need at an affordable price. These standards should 1)ensure that plans provide coverage for a comprehensive set of necessary services; 2) define the scope of coverage; and 3) include limits on beneficiaries' total out-of-pocket costs. The standards should ensure that individuals do not encounter gaps in coverage if they face existing medical conditions or an unexpected illness.

- The following are the existing Minimum Creditable Coverage (MCC) standards, which are the minimum standards that health insurance plans in Massachusetts must meet. This standard includes certain benefits involving preventive and primary care, emergency services, hospital stays, outpatient services, prescription drugs, and mental health services. Specifically, a plan must, among other things:
  - » Cover prescription drugs.
  - » Cover 3 regular doctor visits and check-ups for an individual or 6 for a family before any deductibles.
  - » Cap the deductible at $2,000 for an individual or $4,000 for a family each year.
  - » Cap out-of-pocket spending for non-prescription health services at $5,000 for an individual or $10,000 for a family each year when there is a deductible or co-insurance.
  - » Not total benefits for a sickness or for each year.

Questions remain whether these cost sharing levels are prohibitive for some patients and may increase the likelihood of patient non-compliance with treatment plans, thus increasing the financial risk ACOs bear.

- Standards for benefit design are described in a May 2009 Center for Budget and Policy Priorities article[13] which states "... many enrollees still are likely to end up underinsured for key health services unless an actuarial-value standard is combined with the above requirement that all plans offer basic comprehensive coverage." Additional requirements suggested in the article include: insurers must not place harmful limits on coverage; plans must include adequate protections against high out-of-pocket costs, and insurers should cover preventive care at little or no cost to the beneficiary.

B.) Incentives for consumers must be aligned with provider incentives to make the new model work.

- **Consumer engagement is a key piece of the puzzle.** Policymakers must understand that a substantial consumer engagement and education effort must be made prior to implementation of a global payment system. Consumers will need to be educated *upfront* so that they understand the changes in their benefit design, or else they may make choices inconsistent with that design, or worse yet, blame providers for their dissatisfaction with access and choice. Payment reform efforts must include consumer education efforts — by the state, health insurance companies and other entities. It is crucial that providers are not put in the position of trying to explain these issues to consumers at the time of service.
- A crucial issue is **enrollee choice**. While the Commission's report acknowledges that "employers can maximize the benefit of payment reform by aligning the consumer incentives that are implicit in their benefit designs", the report does "not require employers to modify their health plan designs". A system that gives consumers/patients unlimited choice to get whatever care they want, whenever and wherever they want it seems incompatible with a model that puts the provider (ACO) at risk for all costs related to the care of the patient.
  - » In its consumer outreach, education and, in particular, in benefit design, the state must promote mechanisms that align consumer and ACO incentives. Particular attention

must be given to how consumers would respond to restricted choice; on the flip side, we must determine what implications unrestricted consumer choice will have on the sought-for efficiencies and savings from shifting to a global payment system.

"Under the proposed Massachusetts reforms, all health plans would "require the selection of a primary care physician... Although patients in some plans already obtain their care under such arrangements, many others have greater flexibility in choosing doctors and seeing specialists... However, allowing a greater choice of physicians, hospitals, and medicines for patients who were willing (and able) to pay more would undermine the cost-control, quality-improvement, and care-coordination purposes of global payments."

***Robert Steinbrook**, M.D., The End of Fee-for-Service Medicine? Proposals for Payment Reform in Massachusetts, New England Journal of Medicine*[14]

How to Encourage Patients to Stay with Particular Providers[15]

"Provide education for consumers on the value of selecting and consistently utilizing a primary care provider (or appropriate specialist) as a medical home."

"Reduce copayments and co-insurance for patients utilizing a primary care provider (or appropriate specialist) as a medical home."

"Require consumers to pay a one-time fee for switching primary care providers unless there are appropriate justifications (e.g., a change in the consumer's residence or the provider's location, poor quality ratings of the provider, etc.)."

"Require consumers to accept a greater share of the financial risk for their care (e.g., through higher cost-sharing for hospitalizations for ambulatory-care-sensitive conditions) if they do not select a medical home or otherwise use a consistent provider for their care."

"Require providers to establish "carve-out credits" for consumers if the consumers choose to use services other than those provided or recommended by the provider within a bundled price. A patient may be willing to use a consistent provider for their primary care and some portion of the services they need, but they may want the flexibility to use some services other than those recommended by their provider, or they may want to obtain some of the recom mended services from other providers. To the extent that those services are included in the bundled payment to the patient's primary provider, a mechanism is needed to enable the patient to obtain them from other providers without penalizing the primary provider or restricting the patient's options... This can be facilitated if providers pre-define the "credits" that patients will receive from the bundled payment if they use alternative providers for a particular service. The primary provider would agree to pay the alternative provider the amount of the credit, and the patient would be responsible for paying the remainder of the alternative provider's price."

***Harold Miller**, "From concept to reality: Implementing fundamental reforms in Health care payment systems to support value-driven health care."*

Policymakers should evaluate and incorporate these and/or other options in order to determine which would best serve the need to align consumer and provider incentives under the new payment system.

- In addition, while findings and recommendations resulting from comparative effectiveness research may support hospitals' and providers' efforts to make and offer 'better' care, patients offered aspirin instead of an angioplasty might feel disappointed and cheated. Similarly, promoting healthy behaviors is a daunting task and consumer uptake has been low, despite consumer-friendly information and websites, health plan incentives etc. Without a **strong combination of incentives and disincentives**, consumer behavior may not be influenced much by information alone.
- **Role of employers in benefit design.** Employers – by offering plan designs that incorporate incentives for patients to participate in and take responsibility for their own care and that realign incentives for payers, providers and patients – are crucial to the success of a global payment system. Benefit design and benefit levels determine out-of- pocket expenses for patients, as well as affordability, which influences a patient's ability to adhere to recommended treatment regimes, risk for acute episodes of chronically ill patients, and providers' risk for bad debt. Therefore, without drawing some parameters around benefit design, and getting some form of commitment from employers that they will maintain benefit levels, the risk to ACOs from non-compliance and bad debt will be very high.
- **Value Based Benefit Design** should be evaluated and adopted as a way to "encourage the use of services when the clinical benefits exceed the cost and likewise discourages the use of services when the benefits do not justify the cost."[16]

- Special emphasis needs to be placed on benefit designs that facilitate comprehensive and coordinated **treatment across provider settings** for chronic diseases. MHA believes that the management of key chronic conditions such as diabetes should be actively pursued as important intermediate steps in a movement towards global capitation.

C.) Out-of-network or out-of-ACO care:

- While ACOs must bear the responsibility for maintaining quality of care and accessibility in their provider networks to encourage in-network utilization, ACOs cannot be expected to take on the entire risk of patients that seek care outside the network. So there has to be some risk sharing between the patient/ACO/insurance plans in these cases and the scope of that risk sharing, and the role of health plans in such cases, should be understood and defined.
- At the same time, we must recognize that some patients will appropriately need or want to get care from a provider who is not included in his ACO and we must develop feasible approaches to payment and pricing for these cases. Otherwise, if ACO#1 feels that it will be forced to pay a huge amount for services provided by ACO#2 (for the services that ACO#1 does not provide but ACO#2 does), every ACO will feel compelled to create its own services even if they are duplicative.

C.) ACCOUNTABLE CARE ORGANIZATION (ACO) FORMATION

Several key issues must be addressed before regarding the formation, structure and oversight of Accountable Care Organizations (ACOs). We divide these into **Critical Mass Issues** and **ACO Formation Issues**.

A.) Critical Mass Issues

The Commission recognized in its recommendations the need for participation by both private and public payers in a global payment system to "ensure alignment of financial incentives for providers treating patients covered by different payers." A critical mass of the total patient population and total provider payments would need to be paid under a global payment system to both justify and drive the considerable provider investment[17] that will be needed to make this transformational change. There are at least 3 questions to address related to critical mass:

ERISA ISSUES: Some large employers operate their own group health plans, as opposed to purchasing insurance from an insurance company. Typically the large employer pays a third party (which could be an insurance company or other administrator of health care claims) to administer the plan that it has designed for its employees – the large employer pays the costs (claims plus administration) directly. In Massachusetts, a large and growing proportion of the state's population is in these self-insured health plans.

"...ongoing shift away from insured products to self-insurance. At the beginning of the decade Harvard Pilgrim's book of business was 75% insured and 25% self-insured. It is now 50-50, with self-insurance projected to grow further. Most plans are experiencing a similar trend"

***Bruce Bullen**, Interim Chief Executive Officer of Harvard Pilgrim Health Care, Blog post "Health Reform and the "Bifurcated" Health Insurance Marketplace" Sept 22, 2009*

Self-insured plans are regulated by federal law, the Employee Retirement Income Security Act (ERISA) law, not by state law. Courts have held that the ERISA supersedes or preempts some state health care initiatives, such as mandates on coverage and some types of managed care plan standards, if they have a substantial impact on the structure or administration of self-insured health plans or if they provide for alternative remedies. Therefore, as we pursue payment reform, ERISA preemption becomes relevant as a potential limit on the scope and type of reform we will be able to enact.

If payment reform is to encompass services provided to as many residents of the Commonwealth as possible, then some sort of accommodation would need to be obtained from ERISA through an action by the federal government (such as an ERISA waiver). Absent this accommodation, payment reform that sought to set payment rates or methodologies for use by self-

insured plans would be open to legal challenges (based on state regulation of health plans and insurers).

In addition, there might be a perverse incentive for large employer groups in the state to self- insure to avoid being included in the global payment system. Researchers[18] have pointed out that since ERISA's passage three decades ago, there has been an explosion in the number of employers choosing to self-insure their health benefits plans and then purchase "stop-loss" insurance for the plan in order to avoid both state mandates and insurance risk. On the other hand, if self-insured plans are exempted from participating in the global payment system, the risk pool sizes for some ACOs could fall to actuarially unsound levels and the critical mass described above might not be reached.

MEDICARE PARTICIPATION: In the aggregate, hospitals in the state obtain more than a third of their revenue from the Medicare program. Medicare financing is critical to the state's providers as is Medicare medical education funding, capital and disproportionate share payments. The Special Commission recognized in its report that Medicare participation in the new system is critical for success and addressed the need to obtain a Medicare waiver:

"Federal law permits the Secretary of Health and Human Services to waive certain provisions of the Social Security Act to demonstrate new approaches to provider reimbursement. Such demonstrations may include: testing alternative payment methodologies; demonstrating new delivery systems; and coverage of additional services to improve the overall efficiency of Medicare. However, unlike Medicaid waivers, participation in a Medicare waiver is voluntary unless authorized by specific federal legislation. Moreover, implementation of global payment for Medicare beneficiaries is likely to require waivers of both Part A and Part B relating to conditions of and limitations on payment of services (Section 1814); payment to providers of services (Section 1815); payment of benefits (Section 1833); special payment rules for particular items and services (Section 1834); procedure for payment of claims of providers of services (Section 1835); and provisions relating to the administration of part A (Section 1816) and part B (Section 1842). Section 222 waivers only allow for payment methodology changes. If the state's ultimate design requires waivers of other provisions of the Medicare law, the state may need Congressional action to allow for a waiver of such provisions (Bailit and Waldman 2009).

However, since providers obtain such a large portion of their revenue from Medicare, it is essential that critical system design issues be resolved before providers could support Medicare participation in a global payment system.

- The Medicare statute provides beneficiaries with the choice of being in either traditional fee-for-service Medicare or in a Medicare Managed Care plan (Medicare Part C). The Commission's report states that "the patient's selection of a primary care provider will direct insurer payments to the ACO with which the patient's primary care physician is affiliated." This implies that Medicare beneficiaries will be required to choose PCPs and therefore "belong" to an ACO. It would seem that this requirement amounts to a mandated **insurance product** for Medicare beneficiaries. How does current law accommodate such a requirement?
- On the other hand, if **Medicare beneficiary 'choice'** remains unrestricted and Medicare beneficiaries can opt for care either within or outside of the ACO to which their PCP belongs, risk adjusting and setting appropriate per-member payment levels for Medicare beneficiaries will be very difficult since the probability of their seeking out-of-network care will have to be factored in.
  "...research has shown that among Medicare beneficiaries, the average patient saw two primary care physicians and five specialists, working in a median of four practices, over the course of a year. Patients with chronic conditions saw a larger number of physicians and physician practices."[19]
- In addition, what severity risk adjustment metrics would be used for Medicare beneficiaries? The same as for all other patients, or those that are already in use by the Medicare program? Reimbursement levels could vary greatly depending on the risk metrics used, and assuming that the Medicare waiver is budget neutral, the resulting swings in reimbursement to different providers could be significant.
- The Medicare payment system incorporates **adjustments and special payments** within its structure such as the area wage index, disproportionate share, medical education payments, pass-through payments, end stage renal disease payments, etc. We must determine how to account for and treat these payments in an all-payer global payment system. For example, the state's hospitals received more than $476 million in indirect and direct medical education payments from the Medicare program in 2007; unless the new system accounts for these payments, either by building in appropriate adjustments or developing an acceptable alternative methodology that makes these hospitals whole, it will be impossible to sustain provider support for inclusion of Medicare in a global payment system.

- Similarly, Medicare provides reimbursement for a variety of services such as rehabilitation, psychiatric care, skilled nursing, long term care, home health etc. All these payments will have to be incorporated into the global payment structure.

MEDICAID PARTICIPATION: The continued existence of, and growth in, the Medicaid underpayment gap threatens the sustainability of the first phase of health care reform in the state. A key priority in the historic healthcare reform law was to increase Medicaid payments to hospitals and physicians over time so that they become more aligned with the cost of care. While progress was made initially, MHA's current assessment is that the underpayment gap for hospitals will be larger in 2010 than before the reform law was enacted, creating a growing underpayment gap that fails to meet the cost of care provided to Medicaid patients. This underpayment gap affects not only hospitals, but the communities they serve, including insurance beneficiaries, employers, and all those committed to making healthcare reform a success. The underpayment gap also decreases the likelihood that physicians will participate in all-payer payment reform efforts. We must agree on how to fill the underpayment gap before implementation of a global payment system or any fundamental redesign of the payment system.

B.) ACO Formation Issues

ACO COMPOSITION: In its June 2009 *Report to Congress*, MedPAC identifies common design issues for ACOs and states that "All ACOs would be required to have a panel of primary care physicians, specialists, and at least one hospital."

» We agree with MedPAC that not only should every ACO include at least one hospital but also, hospital(s) would have to be part of the governance of the ACO to ensure the maintenance of needed hospital and standby capacity in a community.
In addition, if there are to be ACOs, they offer an opportunity to improve integration of inpatient and outpatient care and promote joint accountability for care delivery across providers and across time. Hospitals and health care systems are well-positioned to provide the organizational structure that underlies the functioning of a successful ACO.

ACO SIZE: MedPAC also states that ACOs must "include a large number of physicians to reduce volatility" and that "given the random variation in costs for small providers, we expect ACOs would need to have more than 50 physicians and more than 5,000 patients." Clearly, it would be necessary to determine the ideal size of ACOs with requirements for minimum/maximum number of members to ensure actuarial soundness, risk spread, and revenue predictability. The Network for Regional Health Care Improvement in a paper[20] describes the ways in which provider size matters in payment reform efforts:

For the purposes of payment reform, a provider's size (as measured by the number of patients the provider cares for) does matter, for (at least) three reasons:

1. to the extent that the payment to the provider is based, at least in part, on outcomes, the provider needs to care for a large enough number of patients (all of whom are paid for under the new payment system) to enable statistically valid quality measurement;

2. to the extent that the provider is responsible for using the payment to cover low probability, but high cost events (e.g., if a primary care practice is responsible for covering the costs of hospitalizations for chronic disease patients under a condition-specific capitation payment), a provider with a small number of patients will experience larger swings in cash flow when those low-probability events occur; and

3. to the extent that the provider needs to increase its fixed costs to adequately manage patient care or manage its own finances (e.g., purchasing an electronic health record system, hiring a nurse care manager, etc.), it may not be able to fully recover those costs without an adequate number of patients. (The calculation of this will depend on the exact structure of the payment system and the cost item involved.)

By definition, larger providers have more patients, and are thereby more likely to meet these criteria than small providers. However, there are ways that small providers can join together to address these issues without having to formally merge into larger organizations.

ACO JOINT DECISION MAKING: MedPAC further states: "For an ACO to have joint decision making, there would be a need for some type of formal organizational structure... For both voluntary and mandatory models, formal contracts, decision systems, and data systems would be critical to the ACO and its constituent providers' success." Appropriate laws and regulations for the creation and operation of this kind of "formal organizational structure" would be needed. These regulations include but are not limited to: oversight, insurance licensure, and contracting. For example, under the new payment system, since ACOs would assume risk, would

insurance licensure be required? The manner in which the regulations interplay with existing state and federal laws and regulations would have to be understood. For instance, if providers form ACOs, what explicit state/federal action would be required for the transition of independent entities to "integrated" systems to provide a safe harbor from anti-trust laws?

- U.S. antitrust laws generally prohibit otherwise competing doctors and hospitals from negotiating jointly with health insurers. However, the **Clinical Integration Standards** of the Federal Trade Commission (FTC) could provide a safe harbor:
  "[D]octors and hospitals willing to use joint contracting with PPOs as an integral part of an innovative program to accelerate the implementation of advanced clinical technologies, facilitate the adoption of evidence-based medicine, and generally reduce the underuse, overuse, and misuse of clinical resources, clinical integration ceases to simply be a matter of antitrust compliance and becomes instead a powerful business and clinical strategy. Such collaborations should allow doctors and hospitals to proceed in confidence that, with proper advice and implementation, their efforts will not only satisfy FTC enforcers but will also leave them well-positioned to compete in their local market on the basis of providing high quality health care, and not on the basis of unit cost alone."[21] If regulations on the definition, structure and operation of ACOs under the new payment model are developed, they should be consistent with the FTC's Clinical Integration Standards.

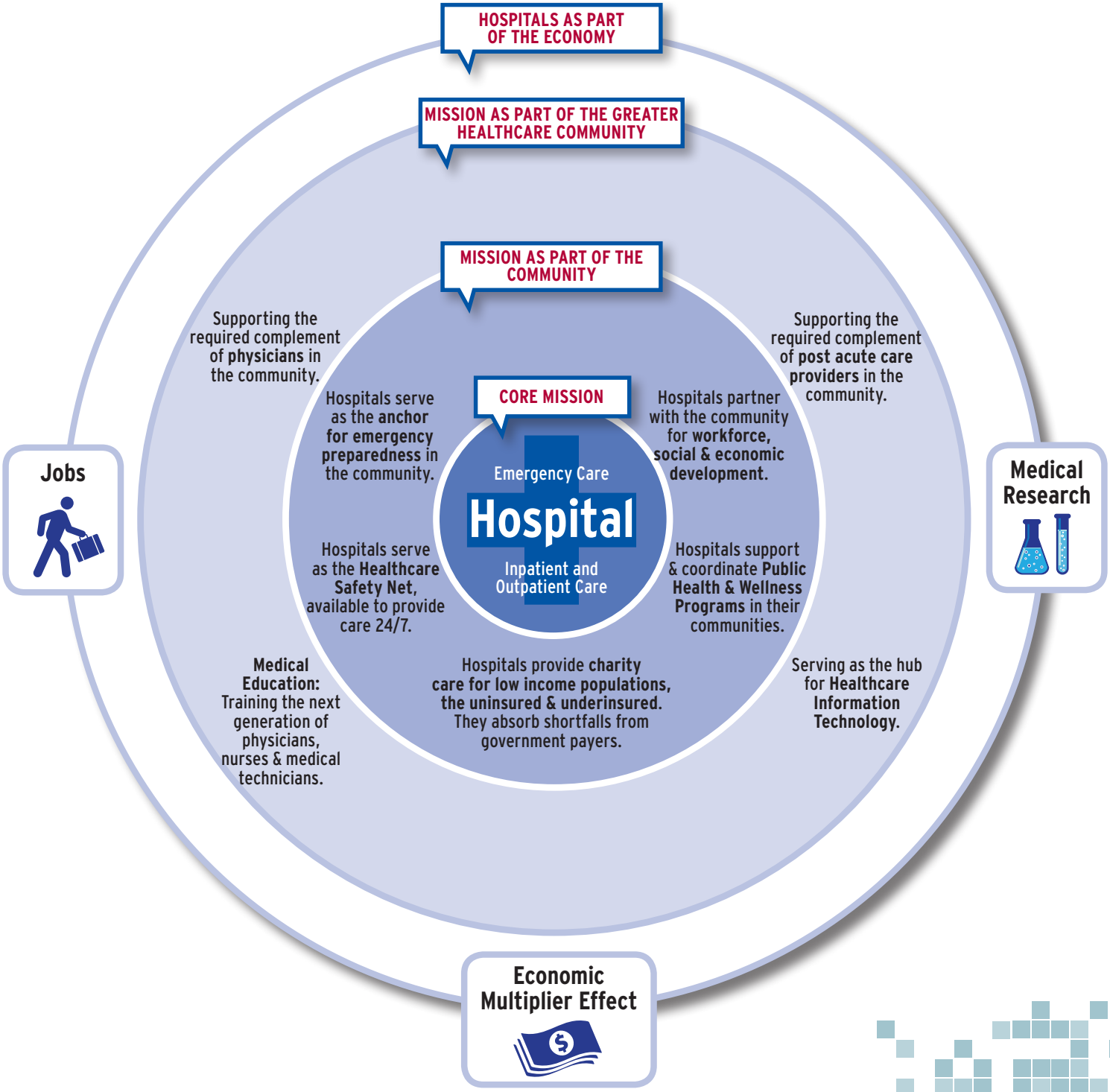
INFRASTRUCTURE/INFORMATION TECHNOLOGY REQUIREMENTS: ACOs would need information technology capabilities that most providers currently do not have, to operate in the new model of risk assumption.

- We must determine up front what **IT capabilities** will be needed. ACOs will need to accumulate health status to support risk adjustment; service utilization information on their covered population for care management and forecasting services and outcomes information to payers and others to support quality measurement and reporting programs. IT capabilities would therefore continue to be critical after the initial transition stage for these, as well as for member service communications and management and employer/purchaser communications and management. Equipping all physicians with Electronic Health Records (EHR) and building Health Information Exchanges (HIE) would enable managing patient care through ACOs but merely having an EHR is inadequate since it only tells the provider what services have been delivered to the patient, not services other providers have delivered[22]. Capacity for integration of such data into a population-based model that can be used for care coordination and management (such as a patient registry) would also be essential.
- We must determine the **provisions that will be made to assure provider acquisition of these capabilities**. We must have a better understanding of the size of the upfront infrastructure costs and the challenges that providers will face in finding the funds to cover this cost. One way to do this would be to have the state "score" the needed investment. The state should consider mandating infrastructure support in payment contracts.
- While providers will be able to make headway in acquiring IT capabilities using the federal funding provided as part of the stimulus bill, more support will likely be needed. This will depend on how high the bar is set for "meaningful use," how much additional support the state provides moving forward to help build the HIE(s) and assist HIT adoption/expansion in other ways.
- A global payment system makes a provider accountable for the cost of care given to patients. This requires a very different set of skills than many providers have today and there is a risk of failure even with appropriate risk-adjustment[23]. ACOs would need support beyond information technology development, including actuarial and financial capabilities consistent with expectations of accepting risk. They would also need to develop clinical and organizational management capacity, both of which require financial resources and time.

ROLE OF INSURANCE COMPANIES: Since different ACOs would have different capabilities, we believe that ACOs should have the option of relying on insurance carriers' systems and procedures to perform such functions as utilization management, referrals, authorizing and dispensing funds to providers within an ACO.

D.) SOCIETAL NEEDS

Hospitals will need assurance that societal needs will be accommodated and supported under the new system. We think of societal needs as the role of the healthcare system, and hospitals in particular, in maintaining and enhancing the general welfare of society. The illustration below shows this ripple effect: the core mission of a hospital, its contributions to the community, its role as part of the greater healthcare community, and the economy as a whole.



We have serious concerns about how the proposed changes in the healthcare payment system will affect the ability to meet these societal needs. These concerns include:

A.) Maintenance of essential hospital operations in each community on a 24-hour, 7-days-a-week basis. Development of the global payment system would have to explicitly include consideration of how to ensure the maintenance of necessary and comprehensive hospital capacity in a community. Hospitals provide disaster and epidemic readiness, care of AIDS patients, burn care, intensive care, neonatal and pediatric services, obstetrics and trauma care, mental health and substance abuse services, and more. Not all these services are necessarily economically viable or profitable for hospitals. Hospitals also provide the 24/7 back-up and safety net for the entire community as well as for other care providers – including ambulatory surgery centers, physicians taking time off, nursing homes, mental health facilities, and more. They provide community health education programs and preventive services for individuals and groups such as the indigent, women, children and teens and the elderly.

One of the unintended consequences of disrupting the existing business model by moving to a global payment system is the tremendous leverage it would give to primary care physicians with large patient panels. Such physician groups would have an incentive to build their own ancillary service delivery capacity – e.g. labs, imaging. This would decrease hospital revenue, some of which is used to subsidize and sustain unprofitable but essential services in a community.

B.) Maintenance of a safety-net for uninsured and underinsured patients. An adequate supplemental payment for hospitals and providers will be needed to address free care to low-income uninsured and underinsured, as well as bad debt, especially for those providers that treat a disproportionate share of low-income patients.

A recent *Health Affairs* article[24] discusses the decline in the actuarial value (portion of health expenses covered) by health plans from 2004 to 2007 and the increase in out-of-pocket spending by one-third over the same time period. Underinsurance increased between 2004 and 2007, and financial protection eroded, particularly for low-income and chronically ill population. This trend is likely to continue as the current recession plays out. In a global payment system, this trend would increase the likelihood of non-compliance on the part of the patient population, more acute episodes for chronically ill patients as well as bad debt. It would be necessary to build in a mechanism to protect (through benefit design) and compensate providers for unexpected levels of bad debt.

MHA projects Health Safety Net costs – covering most, but not all, hospital and health center uncompensated care costs – will top $450 million in fiscal year 2010. Currently, funding for the Health Safety Net (HSN) in Massachusetts partially comes from a provider tax on hospitals. The global payment rate should account for this tax expense and, if not, the provider tax should be eliminated altogether and a surcharge on payers should be used to fund the uncompensated care and bad debt, as was the case during the last Massachusetts hospital rate setting period.

C.) Maintenance of medical education capacity for physicians, nurses and allied medical professionals: Each year, the Commonwealth's teaching hospitals educate a steady source of well-trained medical professionals to meet the needs of Massachusetts patients. The Commonwealth enjoys the fourth highest retention rate of all states, with more than 55% of all actively practicing physicians in Massachusetts having received their training in state. While there is general agreement that support for graduate medical education (GME) is essential to the continued success of health reform at the state level and expanded access at the national level, state funding for GME through the Medicaid program has been eliminated. Massachusetts' teaching hospitals also play a critical role in the state's and economy, with medical schools and teaching hospitals having an impact of more than $29 billion on the state's economy. Funding to support graduate medical education comes from many sources and any new payment system must adequately account for and fund this critical societal need.

D.) Maintenance of a robust research capacity for the continued development of improved treatments for disease and injury. Significant funds flow into Massachusetts for medical research, education, and services. The state ranks second (to California) in grants from the National Institutes of Health (NIH), receiving $2.23 billion in 2007. The city of Boston, for 14 consecutive years, has led all U.S. cities whose institutions received NIH funding, garnering $1.6 billion in NIH grants in 2007. Design flaws in the new global payment system, including, but not limited to, the need for adequate payment for patient care and support for medical education, could undermine the capacity of our institutions to maintain leadership in medical research and innovation.

E.) OVERSIGHT ENTITY-FORM AND FUNCTION

Given the increasingly complex nature of the health environment, it is essential that there be a thorough examination of what type of oversight would be put in place before we embark upon the transformational change that the Commission recommends:

"The entity charged with steering implementation of the new payment system could be a new, independent Board consisting of members that are subject-matter experts. Areas of expertise may include (but may not be limited to) physician practice finance, hospital finance, provider organization and insurer operations, health care payment, clinical care, and consumer issues. This new, independent Board would be supported and staffed by existing state entities or agencies. Alternatively, responsibility for steering implementation of the new payment system could be assigned to an Executive Branch agency that would be advised by an independent Advisory Board with expertise in the previously mentioned areas".

The oversight entity or agency must be explicitly assigned responsibility to assure the continued functioning and financial viability of the Massachusetts health care system. The characteristics of the entity, including its composition, authority, responsibilities, resources and independence would significantly influence its effectiveness. Some of the questions to answer in this context include:

A.) The nature of the oversight entity: Would an independent board or a government agency with advisory board better serve this purpose? It might be that the most appropriate oversight entity would be one entirely different from either option envisioned by the Commission. Given the complexity of implementing payment reform, this issue merits thorough discussion prior to putting the entity in place. However, no matter its final nature, it is imperative to have broad provider (at least hospital and physician) representation on any oversight entity that is charged with overseeing the largest change in our state's health care delivery system in decades.

- The Medicare Payment Advisory Commission (MedPAC) includes provider representatives. This commission is charged with "advising the Congress on payments to private health plans participating in Medicare and providers in Medicare's traditional fee-for-service program; MedPAC is also tasked with analyzing access to care, quality of care, and other issues affecting Medicare." Of the 17 current members, 6 represent hospitals and physicians.
- In Maryland, the Health Services Cost Commission (HSCRC) is an independent agency, charged with regulating hospital rates for all payers in that state. There are 7 members on this Commission, two of which represent hospitals. The commissioners are volunteers and are appointed by the Governor and they come from a variety of healthcare backgrounds, representing consumers, payers, providers and hospital administrators.
- The Connector board has been a positive example of solving difficult issues through processing different points of view. The board consists of representatives from government, labor, consumers and business and has an economist and actuary. One critical voice that is missing on that board however is that of healthcare providers. Those that actually *deliver* medical services daily to the patients that enroll in health plans through the Connector are not represented on the Connector board. While the Connector board has performed admirably to date, it does not represent the full spectrum of the concerns related to care provided to Massachusetts patients.

It would be extremely unwise to exclude providers from any entity charged with overseeing payment reform, given the potentially disastrous consequences for the health care system if this transformational change is not done thoughtfully and deliberately.

B.) Funding for the oversight entity: In its recommendations, the Commission stated that "the resources for the board)... should not be dependent on state funding." It should also be made clear that providers will not be assessed additional taxes to fund this entity.

- The Division of Health Care Finance and Policy currently seems to be the key state agency focused on payment reform analysis. The Division's scope of work has already expanded greatly beyond its historical duties; its healthcare reporting and analysis duties now cover all providers, consumers, insurers, and employers. The Division also regulates and oversees health reform's employer mandates.

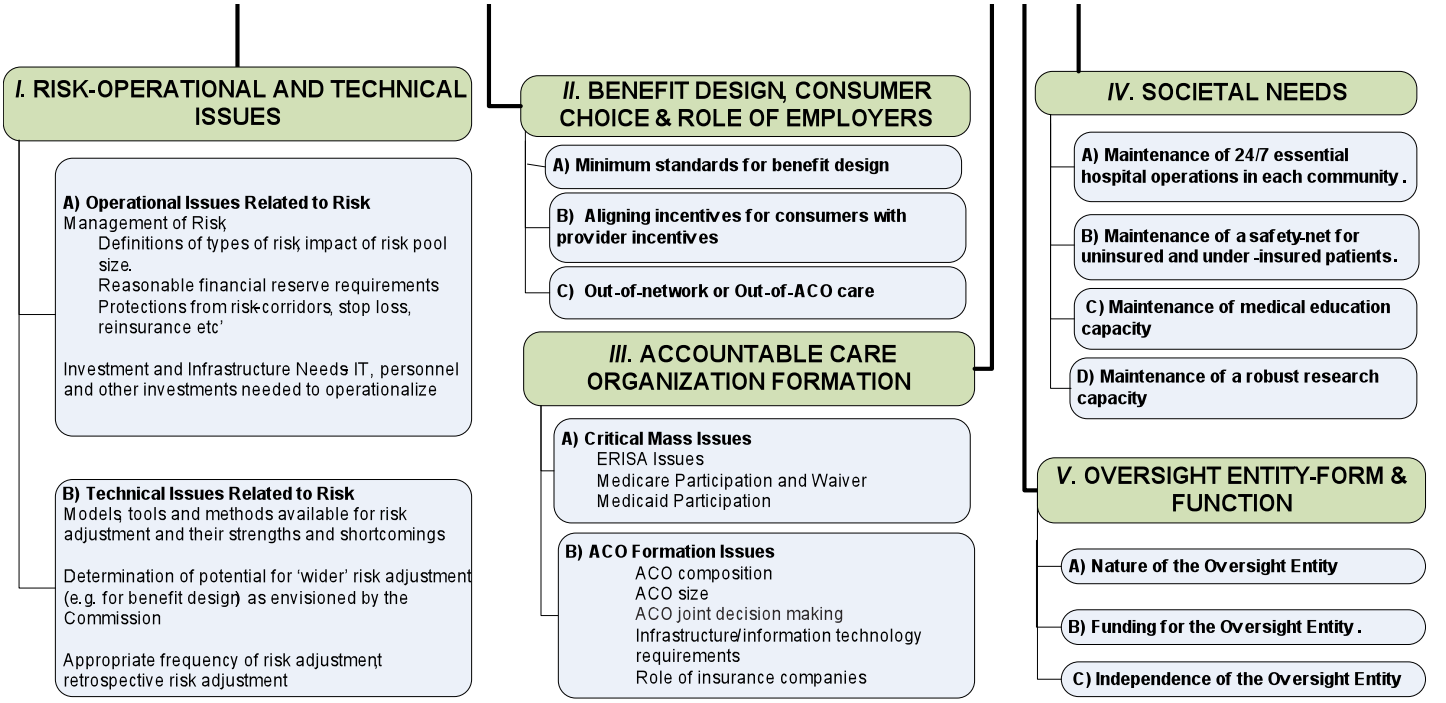
  Acute care hospitals pay for at least *sixty-five percent* of the Division's total expenses, which have grown significantly over the last few years. In fiscal year 2009, the Division will spend an estimated $17.17 million, compared to $13.662 million in fiscal year 2008 – a 26 percent increase. This follows a 9 percent increase from fiscal year 2007. Fiscal year

2005 also witnessed a significant spike in spending of 21 percent. If the Administration and Legislature believe that work of the Division needs to be expanded, and thus its funding requirement, other resources would need to be used. It is unfair to require one segment of the healthcare community (hospitals) to pay for a product from which the entire Commonwealth benefits.

C.) Independence of the Oversight Entity: Any oversight entity put in place would have to be truly independent both in terms of governance and staffing. There should be agreement in advance as to the definition of "independent." The interplay and authority bounds between such an entity and governmental agencies must be clearly delineated. The limitations on the authority of such an entity must be clear and determined in advance after a thorough public discussion.

An Outline of Critical Foundational Issues Impacting Payment Reform

Critical foundational issues that must be addressed before a fundamental and comprehensive reform of the payment system along the lines of the Special Commission's recommendations MHA will addresss each of these areas in a series of briefing papers in the following weeks.



Conclusion

A stable, accessible, high-quality and cost-effective healthcare delivery system is more than a desirable goal for those who need care, those who provide care, and those who pay for care in Massachusetts; it is a necessity. The general direction of the recommendations from the Special Commission on the Healthcare Payment System sets out a vision for such a system. Its central concept of adopting a global payment model to achieve that vision is ambitious and is embraced by some and questioned by others. Since the healthcare sector is so large and complex in Massachusetts and since millions of those who live here are dependent upon it for both their care and their employment, the stakes are high and the challenge of implementing such a system appears daunting. Add to that challenge the fact that no other state has attempted such an extensive redesign of both the healthcare payment and delivery systems.

Those are not reasons to avoid moving forward. However, they are reasons to first understand fully the foundational issues upon which success of payment reform will turn. Before we take irrevocable steps towards fundamentally changing the current payment and delivery systems, we should have an open discussion among all stakeholders about what form success will take in terms of models, resources, time, knowledge, responsibilities, and collaboration. Over time, payment reform built upon some form of global payment could be successful, but this is not a foregone conclusion. For a state that has achieved near universal healthcare coverage – a daunting goal that no other state has reached – there is no reason to back down from the challenge of reforming the payment and delivery systems.

Building on the work of the Special Commission and having a vigorous examination of the global payment model, as well as complementary strategies and alternative models, will ultimately save time and help produce a better result. The Commission's vision of a more efficient, coordinated and collaborative delivery system that is supported by a fair and affordable payment system is the right vision; that is not debatable, and it is achievable. The means for achieving that vision is the challenge before us and with adequate examination, collaboration, creativity, and commitment, that challenge will be successfully achieved. MHA's series of briefing papers is intended to shed light on what the hospital community believes are the foundational issues that must be understood and addressed if reform is to succeed. MHA and its member hospitals are committed to fundamental reform in collaboration with governmental leaders, stakeholders, and the public.

FOOTNOTES:

1, 3: BLS/DUA Q1 2008 Quarterly Census of Employment & Wages (ES-202 data)

2: American Hospital Association, Beyond Health Care, The Economic Contribution of Hospitals, January 2009

4: Funding from NIH, CDC, NSF and AHRQ, 2007

5: Recommendations of the Special Commission on the Health Care Payment System, July 16 2009

7,12,15,20: From concept to reality: Implementing fundamental reforms in Health care payment systems to support value-driven health care, Harold Miller

6, 8: Consumer Directed Healthcare reform with Episode Pricing; Douglas Emery

9, 10,11,22,23: How to create accountable care organizations; Harold Miller, Center for Healthcare Quality and Payment Reform; September 2009.

12: Health Care Benefits–Creating the Optimal Design; Changes in Health Care Financing and Organization, Robert Wood Johnson Foundation

13: Designing benefit standards for a health insurance exchange; Sarah Lueck; Center on Budget and Policy Priorities

14: The End of Fee-for-Service Medicine? Proposals for Payment Reform in Massachusetts; Robert Steinbrook, M.D; NEJM

16: Value-Based Insurance Design; Michael E. Chernew, Allison B. Rosen, and A. Mark Fendrick, Health Affairs

17: Patient Choice Health Care Payment Model Case Study: Ann Robinow

18: Korobkin, Russell B., The Battle Over Self-Insured Health Plans, or 'One Good Loophole Deserves Another'. Yale Journal of Health Policy, Law, and Ethics, Vol. 1, 200519: Care Patterns in Medicare and Their Implications for Pay for Performance; Hoangmai H. Pham; Deborah Schrag et al, New England Journal of Medicine; March 2007

21: Clinical integration: a physician and hospital strategy for better quality, enhanced competition, and collective contracting; Thomas J. Babbo, John P. Marren, and Patrick E. Deady; Hogan Marren, Ltd., Chicago, Illinois

24: Trends In Underinsurance And The Affordability Of Employer Coverage, 2004–2007, Health Affairs June 2009, Jon R. Gabel et al.

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